

Patient Medical History – Adult Male

Patient Label _____

Height _____ Weight _____

Emergency contact person: Name: _____ Phone: _____

Who referred you for this consultation? (Self? Doctor? If so, from what clinic?) _____

Describe the location/symptom/problem that is the reason for your visit: _____

Circle the severity number of the problem on a scale of 1-10: (1=low) 1 2 3 4 5 6 7 8 9 10 (10=high)

When did this problem start? _____

Does anything make this problem better or worse? Please describe: _____

Please circle/check the response that most accurately relates to you.

Problem	Not at all	Less than 1 time in 5	Less than half the time	About half the time	More than half the time	Almost always
Sensation of not emptying bladder.	0	1	2	3	4	5
Urinating less than 2 hours after urination	0	1	2	3	4	5
Stopping & starting during urination	0	1	2	3	4	5
Difficulty in postponing urination	0	1	2	3	4	5
Weak urinary stream	0	1	2	3	4	5
Pushing/straining during urination	0	1	2	3	4	5
How many times do you urinate from the time you go to bed at night until you get up?	0 times	1 time	2 times	3 times	4 times	5 times

Total of the 7 circled items above _____

Problem	Delighted	Pleased	Mostly Satisfied	Mixed	Mostly Dissatisfied	Unhappy	Terrible
If you were to spend the rest of your life with your urinary condition just the way it is now, how would you feel about that?	0	1	2	3	4	5	6
Do you experience any pain with urination?	<input type="checkbox"/> No <input type="checkbox"/> Yes		Are you experiencing any impotence problems? <input type="checkbox"/> No <input type="checkbox"/> Yes				
Do you experience leaking urine?	<input type="checkbox"/> No <input type="checkbox"/> Yes		Have you ever had a kidney or bladder infection? <input type="checkbox"/> No <input type="checkbox"/> Yes				
Do you have blood in your urine?	<input type="checkbox"/> No <input type="checkbox"/> Yes						

Physician use only: (Comments/Notes)

PAST MEDICAL, FAMILY AND SOCIAL HISTORY

Are you or a blood **relative** having problems (now or in the past) with any of the following? No Yes
If yes, please check all boxes that apply.

Have you had **surgery** on any of the following? No Yes
If yes, please check all boxes that apply. **INCLUDE SURGERY DATE:**

	You	Family Member
Anemia	<input type="checkbox"/>	<input type="checkbox"/>
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>
Cancer	<input type="checkbox"/>	<input type="checkbox"/>
Type of cancer:		
Depression	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>
GERD / Acid Reflux	<input type="checkbox"/>	<input type="checkbox"/>
Gout (high uric acid)	<input type="checkbox"/>	<input type="checkbox"/>
Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>
High Cholesterol	<input type="checkbox"/>	<input type="checkbox"/>
Kidney Stones	<input type="checkbox"/>	<input type="checkbox"/>
Liver Disease	<input type="checkbox"/>	<input type="checkbox"/>
Mitral Valve Prolapse	<input type="checkbox"/>	<input type="checkbox"/>
Osteoporosis	<input type="checkbox"/>	<input type="checkbox"/>
Rheumatic Fever	<input type="checkbox"/>	<input type="checkbox"/>
Thyroid Problems	<input type="checkbox"/>	<input type="checkbox"/>
Toxic Exposure	<input type="checkbox"/>	<input type="checkbox"/>
Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>
Other/Explain:	<input type="checkbox"/>	<input type="checkbox"/>

Appendix	<input type="checkbox"/>
Back	<input type="checkbox"/>
Bladder	<input type="checkbox"/>
Breast	<input type="checkbox"/>
Colon	<input type="checkbox"/>
Gallbladder	<input type="checkbox"/>
Heart Bypass	<input type="checkbox"/>
Heart Valve	<input type="checkbox"/>
Hernia	<input type="checkbox"/>
Incontinence	<input type="checkbox"/>
Kidney	<input type="checkbox"/>
Lung	<input type="checkbox"/>
Prostate	<input type="checkbox"/>
Testicle	<input type="checkbox"/>
Thyroid	<input type="checkbox"/>
Total Joint Replacement	<input type="checkbox"/>
Right: <input type="checkbox"/> Hip <input type="checkbox"/> Knee <input type="checkbox"/> Shoulder	
Left: <input type="checkbox"/> Hip <input type="checkbox"/> Knee <input type="checkbox"/> Shoulder	
Urethra	<input type="checkbox"/>
Vasectomy	<input type="checkbox"/>
Other/Explain:	<input type="checkbox"/>

Have you ever had MRSA? No Yes
Positive Mantoux/PPD? No Yes

Do you or did you ever smoke? No Yes
If yes:
How many packs per day? _____

Do you have any allergies? No Yes If yes, please list: Latex allergy? No Yes

Allergy	Type of Reaction (rash, nausea, etc.)

How many years? _____
When did you quit? _____

Do you drink alcohol? No Yes
If yes, how much? _____

Are you taking Aspirin, Coumadin, blood thinners?
 No Yes

Are you on a special diet? No Yes
If yes, explain: _____

Are you taking any medications including herbal and over the counter? No Yes
If yes, please list:

Are you married? No Yes
 Divorced
 Widowed

Name of Medication	Dose	How many times a day?

Are you employed? No Yes Retired
What is your occupation? _____

Do you have children? No Yes
Year(s) of Birth: _____

REVIEW OF SYSTEMS

Do you have any problems related to the following systems? Please circle No or Yes.

Constitutional Symptoms

Fever No Yes
 Chills No Yes
 Headache No Yes
 Other _____ No Yes

Eyes

Blurred vision No Yes
 Double vision No Yes
 Pain No Yes
 Other _____ No Yes

Neurological

Tremors No Yes
 Dizzy spells No Yes
 Numbness/tingling No Yes
 Other _____ No Yes

Endocrine

Excessive thirst No Yes
 Too hot/cold No Yes
 Tired/sluggish No Yes
 Other _____ No Yes

Gastrointestinal

Abdominal pain No Yes
 Nausea/vomiting No Yes
 Indigestion/heartburn No Yes
 Other _____ No Yes

Cardiovascular

Chest pain No Yes
 Varicose veins No Yes
 High blood pressure No Yes
 Other _____ No Yes

Integumentary

Skin rash No Yes
 Boils No Yes
 Persistent itch No Yes
 Other _____ No Yes

Musculoskeletal

Joint pain No Yes
 Neck pain No Yes
 Back pain No Yes
 Other _____ No Yes

Ear/Nose/Throat/Mouth

Ear infection No Yes
 Sore throat No Yes
 Sinus problems No Yes
 Other _____ No Yes

Allergic/Immunologic

Hay fever No Yes
 Drug allergies No Yes
 Other _____ No Yes

Hematologic/Lymphatic

Swollen glands No Yes
 Blood clotting problem No Yes
 Other _____ No Yes

Respiratory

Wheezing No Yes
 Frequent cough No Yes
 Shortness of breath No Yes
 Other _____ No Yes

Genitourinary

Urine retention No Yes
 Painful urination No Yes
 Urinary frequency No Yes
 Other _____ No Yes

Psychologic

Are you generally satisfied with your life? No Yes
 Do you feel severely depressed? No Yes
 Have you ever considered suicide? No Yes
 Other _____ No Yes

Physician use only: (Comments/Notes)

Physician Signature: _____ **Date:** _____